Division of TennCare

STATE OF TENNESSEE

PCMH Provider Information Webinar

12/5/2017

Provider Operating Manual Table of Contents

Today's presentation will mirror the Table of Contents of the Provider Operating Manual

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The PCMH Provider Operating Manual 2018 v1.0 can be found on our website here:
http://tn.gov/assets/entities/hcfa/attachments/PCMHProviderOperatingManual2018.pdf

1 General Information- TennCare PCMH Program Overview

PCMH Organizations commit to:

- Patient-centered access
- Team-based care
- Population health management
- Care management support
- Care coordination and care transitions
- Performance measurement and quality improvement

PCMH Providers receive:

- Ongoing financial support as well as financial rewards for high performance
- Training and custom curriculum
- Actionable quarterly reports on organization performance
- Access to a Care Coordination Tool with member level detail

Benefits to patients, providers, and the health care system:

- Increased quality of care for Medicaid members throughout Tennessee
- Deep collaboration between providers and health plans
- Support and learning opportunities for primary care providers
- Appropriateness of care setting and forms of delivery
- Enhanced chronic condition management
- Referrals to high-value medical and behavioral health care providers
- Reduced readmissions through effective follow-up and transition management

2 How Does an Organization Become a PCMH?

1. **Application**

2. **Eligibility**
   - PCMHs are designated at the Tax ID level
   - Each Tax ID must have at least 500 members with one MCO to qualify

3. **Contracting**
   - MCOs have already started reaching out. If you haven't heard from one of your TennCare contracted MCOs, you can reach out to your provider reps.

3 Which Members are in a PCMH?

- The intent of the PCMH program is to be as broad and inclusive as possible. As a result, all TennCare members enrolled with the MCO are eligible for the PCMH program, including adults and children. CoverKids members are not included at this time.

- All TennCare eligible members attributed to a PCMH are included in the calculation for the monthly activity per member per month (PMPM) payment.

- The Care Coordination Tool will enable organizations to see which patients are attributed and included on their panel.

- Providers are not held accountable for the quality and efficiency outcomes of some members (such as those with third party liability or those with extended nursing home stays). Those members are not included in the outcome payment calculation.

4 What Services Will a PCMH Provide?

All PCMHs must meet the NCQA Recognition Requirement for all sites:

- Maintain Level 2 or 3 PCMH Recognition from the National Committee for Quality Assurance (NCQA). When recognition expires, PCMHs must transition to NCQA's 2017 standards.

OR

- Begin working towards meeting NCQA's 2017[1] PCMH Recognition

NCQA PCMH Recognition organizes requirements into the following categories:

- Team-based care and practice organization
- Knowing and managing your patients
- Patient-centered access and continuity
- Care management and support
- Care coordination and transitions
- Performance measurement and quality improvement

[1]NCQA's 2017 standards are available here: http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH/2017%20PCMH%20Concepts%20Overview.pdf?ver=2017-03-08-220342-490

5 How Will PCMH Organizations Be Paid?

	Objective	Payment
Organization Transformation Payment	• Support initial investment in organization transformation	• $1 per member per month (PMPM) payment • Not risk adjusted • Each organization will receive this payment for their first year of participation
Activity Payment	• Support organizations for the labor and time required to evolve their care delivery models. Organizations may hire new staff (e.g., care coordinators) or change responsibilities for existing staff to support organization transformation. • Incentivize ongoing activity requirements	• Risk-adjusted PMPM payment • Each PCMH will be assigned to a risk band based on the acuity of their membership • MCOs will set payment levels for these bands, but average payment across all organizations will be $4 PMPM
Outcome Payment	• Encourage improvements in total-cost-of care and clinical outcomes • Reward high quality providers	• Annual bonus payment available to high performing PCMHs • High-volume (5,000+ member) PCMH organizations: Shared savings based on total cost of care and quality metrics • Low-volume (<5,000 member) PCMH practices: Bonus payment based on efficiency and quality metrics

Payments in addition to the base primary care payments such as FFS

5 How Will PCMH Organizations Be Paid? PCMH Outcome Payment

The outcome payment is meant to reward high quality providers in shared savings opportunities. This outcome payment is based on performance throughout a full calendar year. The way this payment is calculated varies by panel size:

- **Low volume providers**: PCMHs with less than 5,000 members in a given MCO panel
- **High volume providers**: PCMHs with 5,000 or more members in a given MCO
- It is possible that one PCMH may generate outcome payments as a low volume provider under one MCO and a high volume provider with another MCO. It depends on the panel size with each distinct MCO.
- The following slides depict the step by step calculation for outcome payments to both low volume and high volume providers.

5 How Will PCMH Organizations Be Paid?

PCMH Outcome Payment

Step 1:

Measure Quality

Statewide thresholds are set. Low volume and high volume providers are measured in the same way.

Earn Stars

Step 2:

Measure Efficiency Performance

Low Volume: Measure efficiency metrics against thresholds

High volume: Measure total cost of care compared to other PCPs

Earn Stars

Step 3:

Measure Efficiency Improvement

Low Volume: Measure improvement in efficiency metrics compared to your past performance

High volume: Measure actual savings to total cost of care

Step 4:

Calculate Payment

Low volume: Eligible for up to 25% of shared savings

High volume: Eligible for up to 50% of shared savings

TN

5 How Will Low Volume (less than 5,000 members) PCMH Organizations Be Paid?

Step 1: Measure PCMH quality performance (relative to statewide threshold)

Sample Adult Practice Provider

Quality metric	Threshold	Deno-minator	Performance	Star
Quality Measure 1	≥ 45%	60	55%	★
Quality Measure 2	≥ 60%	50	60%	★
Quality Measure 3	≥ 55%	65	60%	★
Quality Measure 4	≥ 50%	80	20%	☆
Quality Measure 5	≥ 85%	35	50%	☆

Quality stars: ★★★☆☆

At least 2 stars earned? ✓ → Outcome payment eligible ✓

In this example, each Quality Star is worth 10%. See Step 2.

5 How Will Low Volume PCMH Organizations Be Paid?

Step 2: Measure efficiency performance for low volume PCMH organization (relative to MCO set thresholds)

Efficiency metric	Threshold	Performance	Star
ED/ 1000 MM	≤ 70	60	★
Inpatient discharges/ 1000 MM	≤ 15	10	★

Efficiency stars: ★★

Quality and efficiency stars earned:

3 Quality stars at 10% 3*10% = 30%

2 Efficiency stars at 15% 2*15% = 30%

5 How Will Low Volume PCMH Organizations Be Paid?

Step 3: Measure efficiency improvement percentage for low volume PCMH organization (relative to self)

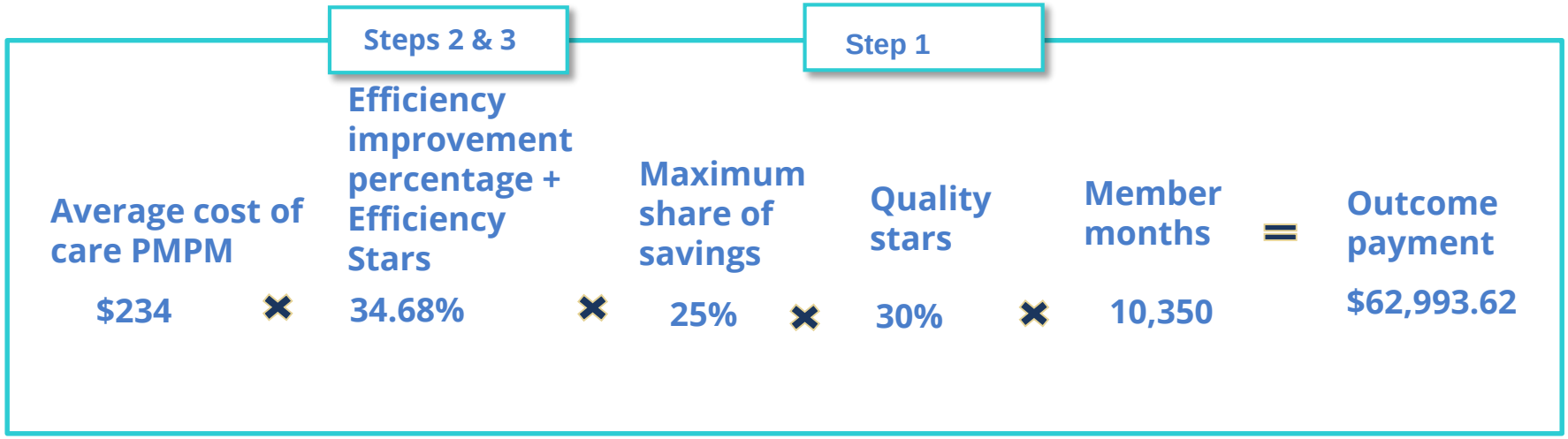
Efficiency metric	Year over Year performance
ED utilization /1000 MM	+2.69%
Inpatient discharges/1000 MM	+6.67%
Average efficiency improvement percentage:	**4.68%**

Efficiency performance

2 Efficiency stars at 15%	2*15%= 30.00%
Efficiency improvement percentage	=4.68%
Efficiency performance	**34.68%**

5 How Will Low Volume PCMH Organizations Be Paid?

Step 4: Calculate payment for low volume PCMH



Set by TennCare; represents average PMPM for PCMH eligible members across all 3 MCOs

Represents provider's efficiency performance relative to self last year and set thresholds on efficiency; 0-50% efficiency performance range

Set by TennCare; represents the maximum percent of the shared savings pool that can be shared with a PCMH

Represents percent of shared savings unlocked by a provider by passing set thresholds on quality; 0-50% range

Represents members on outcome panel

Outcome payment paid to high performing providers after one full year of data and claims run out

*** Illustrative example, not based on real data ***

5 How Will High Volume PCMH Organizations Be Paid? PCMH Outcome Payment

Step 1: Measure quality performance for PCMH (relative to statewide threshold)

Sample Adult Practice Provider

Quality metric	Threshold	Deno-minator	Performance	Star
Quality Measure 1	≥ 45%	60	55%	★
Quality Measure 2	≥ 60%	50	60%	★
Quality Measure 3	≥ 55%	65	52%	☆
Quality Measure 4	≥ 50%	80	20%	☆
Quality Measure 5	≥ 85%	55	30%	☆

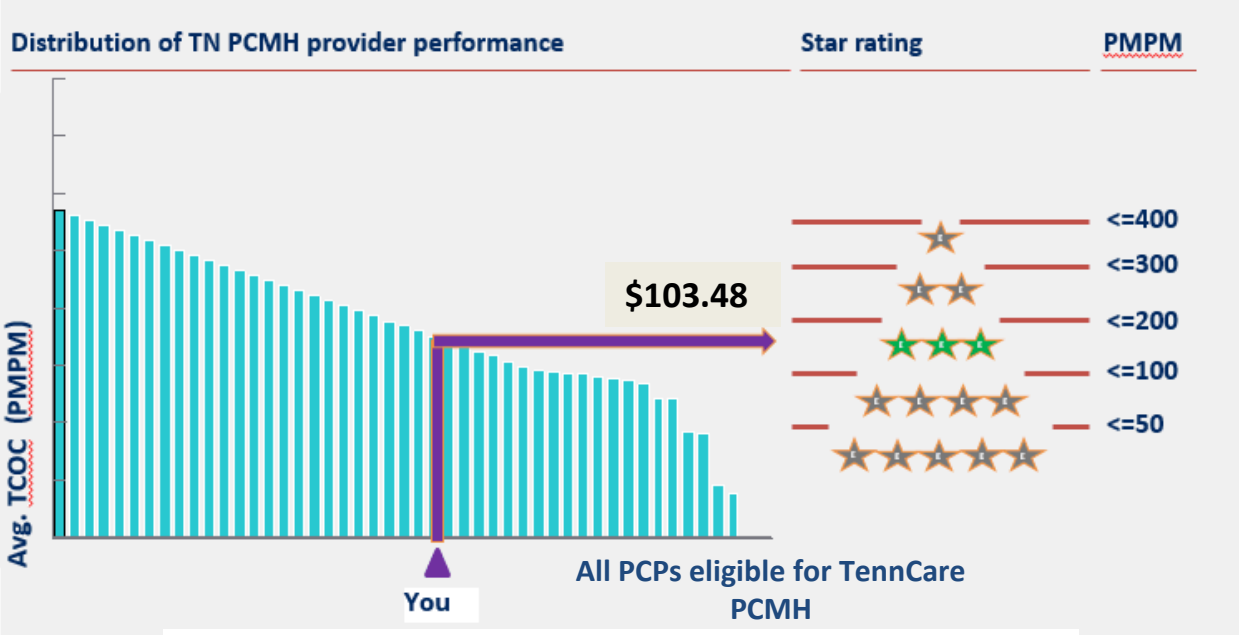
Quality stars: ★★☆☆☆

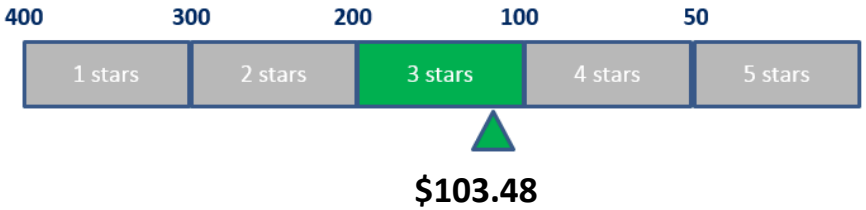
At least 2 stars earned? ✓ → Outcome payment eligible ✓

In this example each Quality Star is worth 10%. See Step 2.

5 How Will High Volume PCMH Organizations Be Paid?

Step 2: Measure Total Cost of Care for PCMH organization (relative to other PCPs)





Efficiency stars: ★★★☆☆

Outcome savings percentage:

2 Quality stars at 10%	2*10% = 20%
3 Efficiency stars at 10%	3*10% = 30%

Outcome savings percentage: **50%**

5 How Will High Volume PCMH Organizations Be Paid?

Step 3: Measure Total Cost of Care Savings for PCMH organization

Risk adjusted baseline	2018 Benchmark (Baseline at 1% growth rate)	Your Actual 2018 TCOC	TCOC Savings Amount
$107.41	$108.48	$103.48	**$5.00**

The baseline is the 3 year risk adjusted average total cost of care.

3 years are used to account for potential year to year variation.

The benchmark is the baseline TCOC adjusted with the annual compound growth rate of 1%

107.41 * (1.01)= 108.48

Risk adjusted TCOC is calculated by summing all included spend, capped at $100k and dividing by the number of months each member was enrolled

The savings amount is the benchmark minus the actual TCOC.

If costs increase, this value is set to zero.

5 How Will High Volume PCMH Organizations Be Paid?

Step 4: Calculate payment for high volume PCMH

Step 3		Steps 1 & 2				
Risk-adjusted TCOC savings amount PMPM		**Maximum share of savings**	**Outcome savings percentage**		**Member months**	**Outcome payment**
$5	×	**50%**	× **50%**	×	**60,000**	= **$75,000.00**
Represents actual TCOC PMPM savings by provider; replaces efficiency improvement percentage		Set by TennCare; represents maximum percent of the shared savings pool that may be shared with a PCMH. Practices that are evaluated on TCOC are given access to a larger pool of shared savings	Represents percent of shared savings unlocked by provider by passing set thresholds on quality and efficiency; 0-100% range		Represents members on outcome panel	Outcome payment paid to high performing providers after one full year of data and claims run out

*** Illustrative example, not based on real data ***

6 PCMH Remediation Process

The remediation process is initiated when a PCMH organization fails to meet deadlines and/or performance targets on required program activities. A PCMH may trigger probation, remediation and/or removal under any of the following circumstances:

1. Not meeting program requirements (e.g. NCQA recognition requirements)
2. Poor performance defined as:
    - PCMH earning 2 or fewer quality stars at the end of a performance period (after 12 months); **or**
    - PCMH earning 1 or fewer efficiency stars at the end of a performance period (after 12 months)
        - PCMH would be put on probation and remain in probation until the end of the next performance period when their performance would be reevaluated
        - If their performance does not improve, then they would be moved into remediation
3. Failure to respond and meet with MCO and/or TennCare

6 PCMH Remediation Process

The remediation process includes three phases outlined below. More details will be available in the Provider Operating Manual.

Probation

- If a PCMH is not meeting performance and program requirements, MCOs and TennCare will notify a provider that they are under review and will stay in clear communication for 6 months.
- If improvements still do not occur, a final probation letter is issued, and the PCMH organization will be required to work with the MCO(s) and those providing coaching to write a corrective action plan (CAP).
- If performance has still not improved, then the MCO(s) will notify TennCare and the PCMH organization will be moved into the remediation phase.

Remediation

- MCO(s) will review the CAP and work with coaches a second time to determine if a PCMH organization is making improvements.
- Activity payments may stop if CAP is not followed or performance and/or program requirement issues are not met.
- MCO(s) may move a PCMH organization from remediation to probation under a revised CAP at their discretion.

Removal from PCMH

- If a PCMH has not fulfilled their CAP, MCOs will terminate all of a PCMH organization's provider payment streams.
- TennCare and MCO(s) reserve the right to remove a PCMH organization from the program in extreme circumstances.

7 How Will Quality and Efficiency be Measured?

Pediatric Practice Quality Metrics

1. **EPSDT screening rate (composite for older kids)**
   - Well-child visits ages 7-11 years
   - Adolescent well-care visits age 12-21
2. **Asthma medication management**
3. **Immunization composite metric**
   - Childhood immunizations
   - Immunizations for adolescents
4. **EPSDT screening rate (composite for younger kids)**
   - Well-child visits first 15 months
   - Well-child visits at 18, 24, & 30 months
   - Well-child visits ages 3-6 years
5. **Weight assessment and nutritional counseling**
   - BMI percentile
   - Counseling for nutrition

Family Practice Quality Metrics

1. **Adult BMI screening**
2. **Antidepressant medication management**
3. **Comprehensive diabetes care (composite 1)**
   - Diabetes eye exam
   - Diabetes BP < 140/90
   - Diabetes nephropathy
4. **Comprehensive diabetes care (composite 2)**
   - Diabetes HbA1c testing
   - Diabetes HbA1c poor control (> 9%)
5. **Asthma medication management**
6. **Immunization composite metric**
   - Childhood immunizations
   - Immunizations for adolescents
7. **EPSDT screening rate (Composite for youngest kids)**
   - Well-child visits first 15 months
   - Well-child visits at 18, 24, & 30 months
8. **EPSDT: Well-child visits ages 3-6 years**
9. **EPSDT Screening (Composite for older kids)**
   - Well-child visits ages 7-11 years
   - Adolescent well-care visits age 12-21
10. **Weight assessment and nutritional counseling**
    - BMI percentile
    - Counseling for nutrition

7 How Will Quality and Efficiency be Measured? Continued

Adult Practice Quality Metrics

1. **Adult BMI screening**
2. **Antidepressant medication management**
3. **EPSDT: Adolescent well-care visits age 12-21**
4. **Comprehensive diabetes care (composite 1)**
   - Diabetes care: eye exam
   - Diabetes care: BP < 140/90
   - Diabetes care: nephropathy
5. **Comprehensive diabetes care (composite 2)**
   - Diabetes HbA1c testing
   - Diabetes HbA1c poor control (>9%)

7 How Will Quality and Efficiency be Measured? Continued

Low Volume PCMH Efficiency Measures

1. Ambulatory care ED visits per 1,000 member months
2. Inpatient discharges per 1,000 member months

- Each MCO sets efficiency metric thresholds with guidance from the State.
- Pediatric organizations will be held to separate thresholds than family and adult practice PCMHs.

8 Risk Adjustment

Risk adjustment is an essential analytic element of the PCMH program. Risk adjustment will be used in the Tennessee PCMH program in 2 ways:

- Risk adjustment of the activity payments PMPM; and
- Risk adjustment of total cost of care

The Tennessee PCMH program utilizes the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) version 6.1 for risk adjustment.

The Chronic Illness and Disability Payment System (CDPS) is a diagnostic classification system that Medicaid programs can use to make health-based capitated payments for TANF and disabled Medicaid beneficiaries. The CDPS code is provided under license and at a reduced rate to qualified public agencies, educational institutions, and researchers.

9 Reporting

- Each MCO will send providers reports quarterly, detailing their efficiency and quality stars, total cost of care, and potential payments for the relevant performance period.
- Below is a timeline of when you can expect to receive these reports:
  - End of February 2018
    - Preview Report displaying some 2017 data
  - End of May 2018
    - Preview Report displaying full 2017 data
  - End of August 2018
    - Preview Report showing full 2017 data with claims runout
    - 1st Performance Report showing early 2018 data
  - End of November 2018
    - Performance Report displaying some 2018 data

- These quarterly reports aim to provide PCMHs an interim view of the member panels that they will be held accountable for during the performance period.

- Your first performance period for PCMH is January 1 - December 31, 2018.

10 Provider Training

TennCare has contracted with **Navigant** to deliver provider training and technical assistance services to PCMH providers across the State.

The training vendor will conduct an **initial assessment** of each PCMH organization that identifies current capabilities. The results of this assessment will allow the trainer to create a **custom curriculum** for each organization to help in meeting transformation milestones and achieve their NCQA recognition. The custom plan will be refined periodically.

Providers will be encouraged to access this curriculum in various ways including:

- On-site coaching
- Large format conferences
- Smaller regional learning collaboratives
- Live webinars
- Recorded trainings
- Compendium of resources

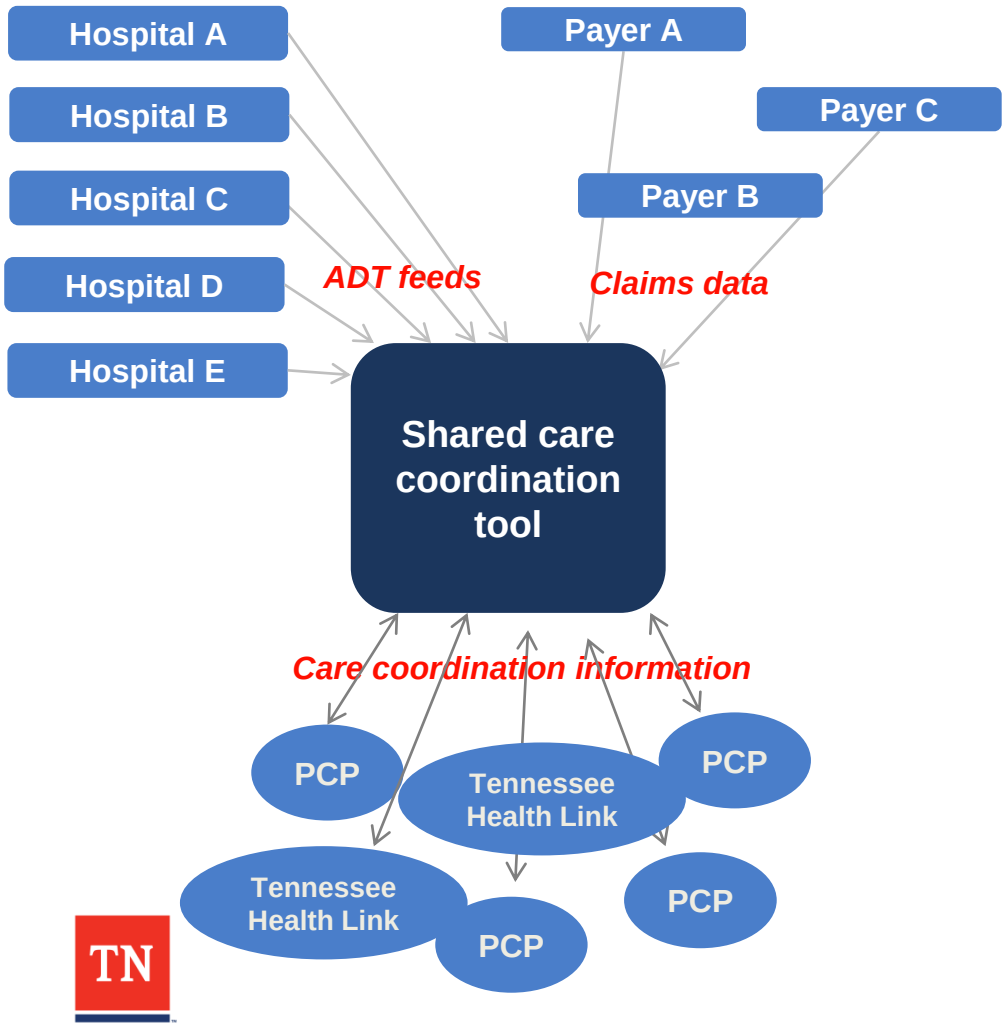
Navigant will also establish and facilitate peer-to peer **learning collaboratives** among organizations to allow PCMH providers to learn from one another's experience.

Dates for 2018 Conferences:

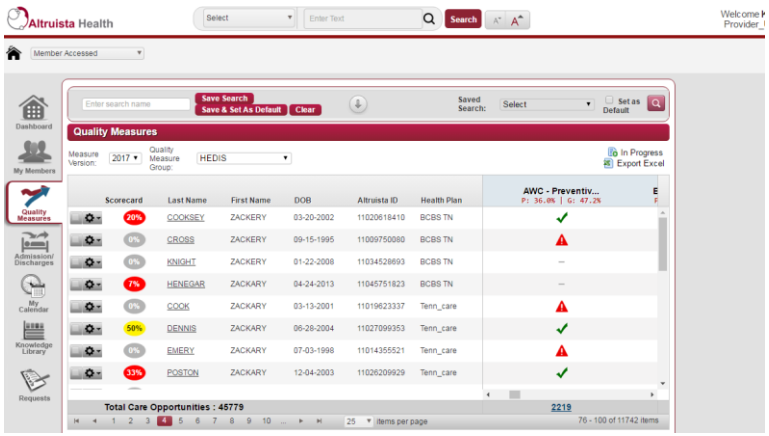
- February 27th, 28th & March 1st (West, Middle, East)
- June 19th, 20th & 21st (West, Middle, East)
- October 23rd, 24th & 25th (West, Middle, East)

Care Coordination Tool

A multi-payer shared care coordination tool will allow primary care providers to implement better care coordination in their offices.



- Identifies a provider's attributed patients' risk scores
- Generates and displays gaps-in-care and creates prioritized workflows for the care team
- Maintains, executes and tracks activities against patient-specific care plans
- Alerts providers of any of their attributed patients' hospital admissions, discharges, and transfers (ADT feeds)



11 Care Coordination Tool: Access Timeline

The State and Altruista are in the process of credentialing providers with Care Coordination Tool (CCT) login information.

- There are multiple steps to complete this process:
  - Organizations must designate a Practice Administrator by **November 29, 2017**.
  - Practice Administrators and additional staff will need to complete required forms on a rolling basis throughout December. Details regarding these forms will be sent via email from HCFA.SPIGCCT@tn.gov and TennCare.SPIG.AdobeSign@tn.gov.
- December 29, 2017: Anticipated timeframe to provide access to the **testing** environment of the CCT
- January 2018 (tentative): 4 week series of CCT webinar training sessions. Details regarding training sessions will be sent via email from HCFA.SPIGCCT@tn.gov.
- Mid-February 2018: Anticipated timeframe to provide access to the **live** environment of the CCT

12 Quality & Efficiency Metrics Appendix

- This appendix provides short descriptions of each of the quality and efficiency measures.
- Many of the measures are HEDIS and will follow the most up to date HEDIS specifications available.
- Providers will be measured against statewide thresholds for quality, as listed in the Appendix.
- Providers will be measured against MCO thresholds for efficiency. These thresholds will be provided during contracting.

Medication Therapy Management (MTM) Pilot Program

- The MTM pilot program will launch in **January 2018**
- It is a **voluntary** program that reimburses pharmacists for providing MTM to eligible members in the PCMH and Health Link programs
  - Pharmacists will be working directly with members to identify, prevent, and resolve medication related problems and collaborate with other healthcare professionals to resolve any identified problems.
- Members who have multiple chronic illnesses and medications with a risk stratification of **Medium-High**, **High**, or **Critical** or members who have pediatric asthma or pediatric diabetes are eligible for MTM
- For a list of pharmacists interested in participating in MTM contact the Tennessee Pharmacist Association (TPA)
  - Executive Director, Micah Cost, PharmD, MS: micah@tnpharm.org
- MTM website: http://www.tn.gov/tenncare/article/medication-therapy-management-pilot-program
- Questions? Email TennCare.MTMpilot@tn.gov

Thank You!

- Questions?

Email Meredith Gonsahn at Meredith.Gonsahn@tn.gov

- More information & Important documents: http://tn.gov/tenncare/article/patient-centered-medical-homes